Designation of Representative

Harvard Pilgrim Health Care

Note: **Incomplete forms cannot be processed and may be returned to you for completion.**
Please call **(888) 609-0692** or TTY# **711** if you need assistance or have questions.

The following elements are required in order for Harvard Pilgrim to process your request.

Member Information			
Member Name			
Member HP ID # (not required for new enrollees without ID#)		**Home Address**	
Date of Birth		**Phone #**	
Designated Representative Information: Person authorized to request and receive your health information and to act on your behalf.			
Name of Designated Representative			
Relationship to Member		**Address**	
Date of Birth		**Phone #**	

Protected Categories: If your information includes any of the following types of protected categories, Harvard Pilgrim will NOT disclose such information UNLESS you specifically authorize us to release/disclose the information to your Designated Representative by providing your initials next to the protected category.

Abortion		**Behavioral Health**		**HIV**	
AIDS/ARC		**Genetic Testing**		**Physical Abuse**	
Alcohol & Substance Abuse		**Domestic Violence**		**Reproductive Health**	
Sexually Transmitted Infection					

TERMS OF THIS DESIGNATION

1. I understand that Harvard Pilgrim will not condition my treatment, enrollment, or eligibility for health insurance benefits on my signing of this Designation.
2. I understand that Harvard Pilgrim will release my health information as directed by the terms and conditions of this Designation. I understand that information once released according to this Designation is out of Harvard Pilgrim's control and Harvard Pilgrim becomes unable to further safeguard such information or prevent redisclosure by the recipient.
3. I understand that I have a right to receive a copy of this Designation.
4. I understand that I may revoke this Designation in writing at any time.
5. I desire this Designation to remain in effect until _____ *(please specify a date)*. I understand that if I do not specify a date, this Designation will remain in effect for two (2) years from the date of signature on this form. (*For a minor, this Designation will expire in two (2) years or the day before the minor's 18th birthday, whichever is earlier.*)

I affirm that I am the above-named Member of Harvard Pilgrim Health Care. I do hereby appoint the above-named individual as my Designated Representative, who I hereby authorize to make decisions related to my health care, coverage, all levels of appeal, and for the purpose of making such decisions, to receive and discuss my health information. I hereby authorize Harvard Pilgrim to disclose my health information to my Designated Representative.

Signature* (required) **Date** (required) **Printed Name*** (required)

This Authorization will only be valid if it is signed by the member or other person with legal authority for the member. If you are not the member, please indicate your relationship to the member below.

☐ **Legally authorized representative** (e.g., power of attorney)

Form of legal authorization:** _____

***You must submit a copy of the legal authorization if not already provided.*

SEND COMPLETED FORM TO:

Harvard Pilgrim Health Care
PO Box 690545, Quincy, MA 02269
Fax: (617) 509-4222

This **Designation of Representative** form is used for a member to authorize an individual to receive information from Harvard Pilgrim and act on their behalf related to their health care.

Note: The Designation of Representative form is not necessary for parents of minor children currently enrolled on the same policy to act on their behalf, unless it is related to a protected category (see additional restrictions below).

Please read the following instructions prior to completing this form.

Designated Representative Information: Please complete this section to identify the individual that is authorized to receive information and act on your behalf.

> **Name of Designated Representative:** You must specifically name the individual authorized to receive your information and act on your behalf. You may not designate an entity/company.

Protected Categories: For individuals age 12 and older, information related to the protected categories will not be disclosed unless specifically authorized by the member. The member may choose to authorize the disclosure of information in none, some, or all of the listed categories.

Who should sign the form?

This form must be signed by the member or a person with legal authority for the member (for example, power of attorney or health care proxy). If signed by someone other than the member, a copy of the legal authorization must also be submitted if not already on file.